Nationally Mandated CAQH CORE Operating Rules and Administrative Simplification

Tuesday, March 27, 2012
1:00 pm to 2:30 pm ET

CAQH
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CAQH
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Session Topics

• Introduction and Industry Context
• Administrative Simplification: Affordable Care Act (ACA) Section 1104
  – Operating Rules: Purpose, Approach and Timeline
• Overview of CAQH CORE Operating Rules
  – What are Operating Rules?
  – Mandated Eligibility and Claim Status Operating Rules
  – Draft Electronic Funds Transfer and Electronic Remittance Advice Operating
    Rules
  – Future ACA Operating Rule Mandates
• Get Started: Implementing Mandated Eligibility and Claims Status Operating
  Rules
  – The Business Case
  – Impact to Third Party Administrators
  – Your Implementation: CAQH CORE Tools Overview
• Question & Answer
Today’s Learning Objectives

Attendees will be able to:

• Summarize the status of operating rules required by the Patient Protection and Affordable Care Act (ACA)

• Review the nationally mandated CAQH CORE Operating Rules and the process for adopting these rules

• Explore the potential impact of administrative operating rules for various healthcare stakeholders, including TPA firms, given the recent mandate

• Acquire the necessary background to initiate an assessment of how mandated operating rules impact your TPA arrangements; explore implementation approaches; and understand the importance of collaboration in implementing the operating rules
Polling Question #1

- Which answer below best describes your organization’s awareness of the January 2013 Eligibility and Claim Status Operating Rule Mandate?
  - 1 = HIPAA Covered Entity; Aware of the impact
  - 2 = HIPAA Covered Entity; Unsure of the impact
  - 3 = Not a HIPAA Covered Entity
  - 4 = Not Applicable
Polling Question #2

- On a scale of 1 to 5, rate your familiarity with the requirements of the January 1, 2013 healthcare operating rule mandate, per Section 1104 of the Patient Protection and Affordable Care Act (ACA)
  - 1 = Not at All
  - 2 = A Little
  - 3 = Some
  - 4 = Working
  - 5 = Strong
CAQH CORE Mission and Participants

• **Mission**: To build consensus among healthcare industry stakeholders on a set of operating rules that facilitate administrative interoperability between providers and health plans
  – Enable providers to submit transactions from the system of their choice (*vendor agnostic*) and quickly receive a standardized response
  – Enable stakeholders to implement in phases that encourage feasible progress in resolving industry business needs while minimizing barriers to adoption
  – Facilitate administrative and clinical data integration

• **Participants**: Over 130 participating organizations representing all aspects of the industry, including health plans that cover 75% of the commercially insured, plus Medicare and several state Medicaid agencies
Industry Context: A Spectrum of Change

- During the next several years *the entire* revenue cycle process will experience significant transformation due to the introduction of operating rules.
- This change can drive interoperability, facilitate greater adoption of standards and generate a responsive, and adaptive, system-wide approach that aligns with other strategic initiatives.
Industry Context: Federally Mandated Operating Rules

• Today, operating rules support existing standards in many high-volume industries, e.g. cellular phones, financial services ... *Consider the ATM*

• Prior to 2005, national operating rules for medical administrative transactions did not exist in healthcare outside of individual trading partner relationships

• In 2005 CAQH CORE, a multi-stakeholder collaboration began voluntary development of industry-wide healthcare operating rules, built on existing standards, to streamline administrative transactions

• In 2010, Section 1104 of the Patient Protection and Affordable Care Act (ACA) required that *all HIPAA covered entities* be compliant with applicable HIPAA standards and *associated operating rules*

*The effective date for the first set of operating rules is in 9 months: Jan 2013. Additional deadlines follow through 2016.*

*The details of how health plans will verify compliance with CMS have not been released; it is anticipated that CMS may issue an NPRM in 2012.*
Operating Rules: Purpose, Approach, ACA Section 1104 Timeline and Compliance
Purpose of Operating Rules

- The Patient Protection and Affordable Care Act (ACA) defines operating rules as “the necessary business rules and guidelines for the electronic exchange of information that are not defined by a standard or its implementation specifications”
- They address gaps in standards, help refine the infrastructure that supports electronic data exchange and recognize interdependencies among transactions; they do not duplicate standards
What are Healthcare Operating Rules?

- Current healthcare operating rules build upon a range of standards - healthcare specific (e.g. ASC X12) and industry neutral (e.g., OASIS, W3C) - and support alignment with the national HIT agenda
- Operating rules and standards work in unison
- Healthcare operating rules pair content and infrastructure rules to help data flow consistently in varied settings and with various vendors

<table>
<thead>
<tr>
<th>Examples of Topics that Healthcare Operating Rules Address:</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Data Content</strong> Enhances what your organization already supports</td>
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<tr>
<td><strong>Infrastructure</strong></td>
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CAQH CORE: ACA Mandated Operating Rule Approach

Operating rule writing and mandated implementation timeframe per ACA legislation

Adoption deadlines to finalize operating rules

- **July 2011**: Eligibility and Claim Status
- **July 2012**: Claims payment/advice and electronic funds transfer (plus health plan ID)
- **July 2014**: Enrollment, Referral authorization, attachments, etc.

Effective dates to implement operating rules

- **January 2013**:
- **January 2014**:
- **January 2016**

Notes:

1. The National Committee on Vital and Health Statistics (NCVHS) is the body designated by the Department of Health and Human Services (HHS) to make recommendations regarding the operating rule authors and the operating rules.
2. The statute defines the relationship between operating rules and standards.
3. Operating rules apply to Health Insurance Portability and Accountability Act of 1996 (HIPAA) covered entities; beyond HIPAA compliance penalties, certification penalties for health plans apply.
4. Per statute, documentation of compliance for health plans may include certification and testing.
ACA Federal Compliance Requirements: *Highlights*

- **All HIPAA covered entities** (health plans, providers, clearinghouses, etc.) must be in compliance with operating rules by their effective dates
  - Due to HITECH in November 2010, OESS (CMS Office of E-Health Standards and Services) penalties for non-compliance have increased, now up to $1.5 million per entity per year; the CMS website details this enforcement process.

- The Administrative Simplification provisions in the ACA require *health plans* “to file a statement with HHS certifying that their data and information systems are in compliance with the standards and operating rules”*
  - According to CMS, regulation detailing the health plan certification process is under development; details surrounding a potential process will be released later this year.
  - **Penalties** for failure to certify will equal $1 per covered life until certification is complete; penalties for deliberate misrepresentation are twice the amount imposed for failure to comply and cannot exceed on an annual basis an amount equal to $20 per covered life or $40 per covered life for deliberate misrepresentation.
  - Certification schedule comes after the various effective dates for standards and operating rules.

- See [March 2012 CAQH CORE Town Hall Presentation](#) for CMS Overview of Federal Regulations on HIPAA Compliance.

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*Refer to [CMS Source](#) for details.

**NOTE:** CAQH CORE will continue to offer its *voluntary* CORE Certification program and will share lessons learned with CMS as the Federal process is developed.
Mandated Eligibility and Claim Status
Operating Rules
Mandated Eligibility and Claim Status Operating Rules: Status

Status and next steps: The first set of operating rules have been adopted into Federal regulation

- July 2011: CMS published CMS-0032-IFC with the following key features:
  - Adopted Phase I and II CAQH CORE Operating Rules, except for Acknowledgements*
  - Highlights CORE Certification is voluntary; further defines relationship between standards and operating rules and analysis of ROI from operating rules implementation

- December 2011: CMS adopted above as a Final Rule; industry implementation efforts underway for the **January 1, 2013 compliance date**, e.g.:
  - Data content: more robust eligibility verification and financials; enhanced error reporting and patient identification
  - Infrastructure: system availability, response times, connectivity and security

- CAQH CORE is committed to assisting with roll-out of the Final Rule and continuing to support maintenance of the rules, e.g., coordinating with CMS on FAQs, hosting education sessions

*On September 22, 2011, NCVHS issued a letter recommending Acknowledgements be adopted as formally recognized standards and the CAQH CORE Operating Rules for these standards also be recognized.
Mandated Eligibility & Claim Status Operating Rules: January 2013 Requirements Scope

<table>
<thead>
<tr>
<th>Rules</th>
<th>High-Level Phase I &amp; II CAQH CORE Requirements</th>
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</thead>
<tbody>
<tr>
<td><strong>Data Content</strong></td>
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</table>
| **Eligibility & Benefits** | • Respond to generic and explicit inquiries for a defined set of 50+ high volume services with:  
  – Health plan name and coverage dates  
  – Static financials (co-pay, co-insurance, base deductibles)  
  – Benefit-specific and base deductible for individual and family  
  – In/Out of network variances  
  – Remaining deductible amounts  
  • Enhanced Patient Identification and Error Reporting requirements |
| **Infrastructure** |  |
| **Eligibility, Benefits AND Claim Status** | • Connectivity via Internet and aligned with NHIN direction, e.g., supports plug and play method (SOAP and digital certificates and clinical/administrative alignment)  
  • Companion Guide – common flow/format  
  • Real-time and batch turnaround times (e.g., 20 seconds or less for real time and next day for batch  
  • System Availability service levels – minimum 86% availability per calendar week  
  • Acknowledgements (transactional)* |

*NOTE: In the Final Rule for Administrative Simplification: Adoption of Operating Rules for Eligibility for a Health Plan and Health Care Claim Status Transaction, requirements pertaining to use of Acknowledgements are NOT included for adoption. Although HHS is not requiring compliance with any operating rule requirements related to Acknowledgements, the Final Rule does note “we are addressing the important role acknowledgements play in EDI by strongly encouraging the industry to implement the acknowledgement requirements in the CAQH CORE rules we are adopting herein.”

A PowerPoint overview of the Phase I & II CAQH CORE Rules is available [HERE](#); the complete rule sets are available [HERE](#).
CAQH CORE Rules 154 and 260 require that health plans and information sources that create a 271 response to a generic 270 inquiry must include:

- The name of the health plan covering the individual (if available)
- Provide patient financials for the static financials of co-insurance, co-payment, and deductible, and return the remaining deductible amount; include in-network and out-of-network coverage and financials for 48 required service types(benefits)

For more detail, see CORE Rules 154 and 260

CAQH CORE Rule 258 requires health plans to **normalize submitted and stored last name** before using the submitted and stored last names:

- If normalized name validated, return 271 with CORE-required content
- If normalized name validated but un-normalized names do not match, return last name as stored by health plan and specified INS segment
- If normalized name not validated, return specified AAA code

For more detail, see CORE Rule 258

CAQH CORE Rule 259 requires health plans to return a **unique combination of one or more AAA segments along with one or more of the submitted patient identifying data elements** in order to communicate the specific errors to the submitter.

The receiver of the 271 response is required to detect all error conditions reported and display to the end user text that uniquely describes the specific error conditions and data elements determined to be missing or invalid.

For more detail, see CORE Rule 259
Eligibility v5010 270/271 & Claim Status v276/277: Uniform Operational Documentation

**Companion Guides**

CAQH CORE Rules 152 and 250 require that Companion Guides covering 270/271 and 276/277 transactions follow the format and flow of the CORE v5010 Master Companion Guide Template. The Companion Guide Template*: Organizes information into distinct sections

- General Information
- Connectivity with the payer
- Transaction-Specific Information
- Key contact information
- Testing with the payer
- Control segment details
- Payer specific business rules
- Allows health plans (information sources) to tailor the document to meet their particular needs while still maintaining a standard template/common structure

*Adapted from the CAQH/WEDI Best Practices Companion Guide Template originally published January 1, 2003

For more detail, see CORE Rules 152 and 250

**System Availability**

CAQH CORE Rules 157 and 250 establish guidelines for system availability and provider support for health plan eligibility and claim status transactions including:

- Minimum of **86 percent system availability** (per calendar week)
- Publish regularly scheduled downtime
- Provide one week advance notice on non-routine downtime
- Provide information within one hour of emergency downtime

For more detail, see CORE Rules 157 and 250

*Adapted from the CAQH/WEDI Best Practices Companion Guide Template originally published January 1, 2003*
Eligibility v5010 270/271 & Claim Status v276/277: Infrastructure

Response Time
(v5010 270/271 & v5010 276/277)

CORE Phase I & II Rules include maximum response processing guidelines:
• Real-time Response of Maximum: 20-second round trip
• Batch (if offered) Response Receipt by 9 pm ET requires response by 7 am ET the next business day
• Conformance with this rule will be considered achieved if entities meet these measures 90 percent of the time within a calendar month

For more detail, see CORE Rules 155, 156 and 250

Acknowledgements*
(v5010 270/271 & v5010 276/277)

CORE Phase I & II Rules include assurances that sent transactions are accurately received and to facilitate health plan correction of errors in outbound messages.

For Real-time transactions, submitter will always receive a response (i.e., a 271 or 999), only one response;
Batch Receivers include Plans, intermediaries and providers will always return a 999 to acknowledge receipt for Rejections and Acceptance

For more detail, see CORE Rules 150, 151 and 250

*NOTE: In the Final Rule for Administrative Simplification: Adoption of Operating Rules for Eligibility for a Health Plan and Health Care Claim Status Transaction, requirements pertaining to use of Acknowledgements are NOT included for adoption. Although HHS is not requiring compliance with any operating rule requirements related to Acknowledgements, the Final Rule does note "we are addressing the important role acknowledgements play in EDI by strongly encouraging the industry to implement the acknowledgement requirements in the CAQH CORE rules we are adopting herein".
Eligibility v5010 270/271 & Claim Status v276/277: Infrastructure (continued)

**Connectivity***
(v5010 270/271 & v5010 276/277)

CORE-certified entities must support HTTP/S 1.1 over the public Internet as a transport method for both batch and real-time eligibility inquiry and response transaction, and claims status; they must follow:

- Real-time and/or batch request submission and response pickup guidelines
- Security and authentication requirements
- Response message options and error notification
- Response time, time out parameters and re-transmission guidelines
- Supports prescriptive submitter authentication, envelope specifications, etc.
- Payload-agnostic, can use to send any type of data

*For more detail, see CORE Rules 153, 250 and 270* 

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**Safe Harbor***
(v5010 270/271 & v5010 276/277)

CORE Phase I & II Connectivity Rules are a “Safe Harbor” rule which provides for a uniform method of exchanging administrative transaction data between health plan and provider – but other methods can be used:

- Applies to information sources performing the role of an HTTP/S server and information receivers performing the role of an HTTP/S client
- Applies to real time transactions (and batch, if offered; batch NOT required)
- Does not require trading partners to remove existing connections that do not match the rule
- Prescriptive submitter authentication, envelope specifications, etc., (SOAP and WSDL, Name/Password or X.509 Certificate)

*Specifically designed to align with key Federal efforts, e.g. NHIN*
Future ACA Operating Rule Mandates
EFT and ERA: Healthcare and Financial Services

- To enable the ACA’s Electronic Funds Transfer (EFT) and Electronic Remittance Advice (ERA) operating rules mandate, there must be coordination between healthcare and financial services.

- 835/ERA is a healthcare standard; EFT/CCD+ used by many industries.

* NCVHS recommended standard, see February 17, 2011 NCVHS Recommendation to HHS Secretary.
EFT and ERA:
Healthcare and Financial Services Collaboration

- **NACHA – The Electronics Payment Association**
  - Established in 1974; a financial services entity whose rules are used by 15,000 banks; NACHA Operating Rules are used by bank throughout the country
  - NACHA manages the development, administration and governance of the ACH Network, the backbone for the electronic movement of money and data
  - The **ACH Network** is a batch processing, electronic payments system governed by The NACHA Operating Rules; it provides for the interbank clearing of electronic payments for participating depository financial institutions

- **CAQH CORE has and continues to be coordinating with NACHA**
  - Began working together in 2005; began coordinating operating rule writing in 2010
  - CAQH CORE participants* identified key areas where new or modified **NACHA Operating Rules** could address current issues in use of NACHA CCD+ transaction for EFT healthcare payments over the ACH Network
  - CAQH CORE continues to assist NACHA in gaining healthcare input on **NACHA Operating Rules** for EFT
Mandated EFT and ERA Operating Rules: Status

• **Progress to Date**
  – In Spring 2011, NCVHS recommended:
    • NACHA as healthcare EFT SDO and ACH CCD+ as standard EFT format
    • CAQH CORE, in collaboration with NACHA, as author for EFT and ERA operating rules (pharmacy to be addressed as appropriate)
  – September 2011: *Draft* CAQH CORE EFT & ERA Operating Rules approved by CAQH CORE Rules Work Group and NCVHS updated on rules’ status
  – November 2011: CAQH CORE Technical Work Group approved voluntary CORE Certification Test Suite
  – December 2011: NCVHS issued a letter recommending HHS adopt the five *Draft* CAQH CORE EFT & ERA Operating Rules
  – **Related step:** January 2012, CMS released Interim Final Rule for the EFT standard
    • *EFT Standard:* CAQH CORE submitted comments on the IFC; CAQH also made available a [Model Letter](#) that entities could use to submit their comments to CMS by March 12, 2012

• **Next Steps**
  – *Healthcare:* Finalize CAQH CORE Operating Rules; CMS will determine appropriateness for mandate
  – *Financial Services:* CAQH CORE coordinates with NACHA on edits to *NACHA Operating Rules* due to future use by healthcare
# Draft CAQH CORE EFT & ERA Operating Rules: Overview

<table>
<thead>
<tr>
<th>Draft Rule</th>
<th>High-Level Requirements</th>
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<tbody>
<tr>
<td><strong>Data Content</strong></td>
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<tr>
<td>Uniform Use of CARCs and RARCs (835) Rule</td>
<td>- Identifies a <em>minimum</em> set of four CAQH CORE-defined Business Scenarios with a <em>maximum</em> set of CAQH CORE-required code combinations that can be applied to convey details of the claim denial or payment to the provider</td>
</tr>
<tr>
<td><strong>Infrastructure</strong></td>
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</tbody>
</table>
| EFT Enrollment Data Rule                        | - Identifies a maximum set of standard data elements for EFT enrollment  
- Outlines a straw man template for paper and electronic collection of the data elements  
- Requires health plan to offer electronic EFT enrollment                                                                                                                                                                                                                               |
| ERA Enrollment Data Rule                        | - Similar to EFT Enrollment Data Rule                                                                                                                                                                                                                                                                                                                  |
| EFT & ERA Reassociation (CCD+/835) Rule         | - Addresses provider receipt of the CAQH CORE-required Minimum ACH CCD+ Data Elements required for reassociation  
- Addresses elapsed time between the sending of the v5010 835 and the CCD+ transactions  
- Requirements for resolving late/missing EFT and ERA transactions  
- Recognition of the role of NACHA Operating Rules for financial institutions                                                                                                                                                                                                       |
| Claim Payment/Advice (835) Infrastructure Rule  | - Specifies use of the CAQH CORE Master Companion Guide Template for the flow and format of such guides  
- Requires entities to support the Phase II CAQH CORE Connectivity Rule  
- Includes Batch Acknowledgement Requirements  
- Defines a dual-delivery (paper/electronic) to facilitate provider transition to electronic remits                                                                                                                |
Impact Summary: Use of Draft CORE EFT and ERA Operating Rules

CAQH CORE Operating Rules for EFT and ERA transactions are designed to improve the flow of healthcare payments and reduce administrative cost.

<table>
<thead>
<tr>
<th>Draft Rule</th>
<th>Current Pain Point / Root Cause</th>
<th>Solution</th>
<th>Benefit / Impact</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Uniform use of CARCs and RARCs (835) Rule</strong></td>
<td>Non-uniform implementation of code sets and semantics</td>
<td>Uniform use of codes (e.g., CARCs and RARCs)</td>
<td>Reduction in • Implementation costs • Code interpretation errors</td>
</tr>
<tr>
<td><strong>EFT and ERA Enrollment Data Rules</strong></td>
<td>Non-uniform collection of enrollment data for EFT and ERA</td>
<td>Uniform enrollment data collection</td>
<td>Enables efficient, predictable and common enrollment processes for providers</td>
</tr>
<tr>
<td><strong>EFT &amp; ERA Re-association (CCD+/835) Rule</strong></td>
<td>Non time-bound and manual re-association of ERA with EFT</td>
<td>Automated and timely re-association of ERA with EFT</td>
<td>• Create efficiencies in re-association process • Reduction in error rates</td>
</tr>
<tr>
<td><strong>Claim Payment/Advice (835) Infrastructure Rule</strong></td>
<td>Lack of common approaches to infrastructure (e.g., connectivity, response time)</td>
<td>Uniform infrastructure and connectivity</td>
<td>• Reduction in implementation costs • Supports more reliable and secure transactions</td>
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Mandated Operating Rules: *Claim Attachments, Enrollment, Prior Authorization and Referrals*

### Status
- November 2011: NCVHS began holding hearings
  - CAQH CORE provided testimony on all three topics and stated interest in serving as operating rule author, key points included:
    - **Claim Attachments**: Communicated current industry landscape implies clinical and administrative coordination is critical, provided examples of potential areas for operating rules; highlighted standards and operating rules will need to work together more than ever if the industry is to meet deadline
    - **Provider Enrollment**: Outlined lessons learned from the CAQH Universal Provider Datasource (UPD) as well as CORE EFT/ERA work
    - **Maintenance of Standards & Operating Rules**: Discussed how these processes can be improved moving forward
- March 1-2, 2012: NCVHS held hearing
  - Reviewed draft HHS update letters; approved revisions & submission of revised letters
    - **Claim Attachments Letter**
    - **Administrative Simplification Provisions in ACA Section 10109 Letter**
    - **Update and Maintenance Process of Standards and Operating Rules Letter**

### Next steps
- Spring 2012: NCVHS to make a recommendation on timing and process for identifying author
Getting Started: Implementing Mandated Eligibility and Claim Status Operating Rules
The Business Case: All Stakeholders

- More robust and accessible eligibility and claim status methods have enhanced the flow of information between providers and health plans
- CAQH CORE Operating Rules help stakeholders leverage investments
  - Common infrastructure supports multiple methods and future transaction types
  - Solutions reusable with new partners
- Streamlined implementation with CAQH CORE partners
  - Better technical skill and resources
  - Less customization, reduced testing
  - Lower cost connectivity using the public internet
- Costs to implement CAQH CORE Operating Rules vary widely, depending on how much technology change is required

* IBM assessed results achieved by Phase I CAQH CORE Operating Rules early adopters (represents 33 million covered lives and 1.2 million providers)
The Business Case: Payers

The CAQH CORE Operating Rules for the Eligibility transaction result in improved servicing capabilities & reduction in health plan administrative cost

• Payers that adopt the Phase I CAQH CORE Operating Rules have reported:
  – Increased total electronic eligibility up 33% in one year
    • Due to shift towards electronic methods, health plans can handle increased verification volumes with the same staff
  – Pairing implementation with organizational-specific eligibility/benefits initiatives yields strong results
    • Providers rapidly take advantage of new capabilities, e.g., real-time transactions
    • Extensive communication to providers, targeted outreach as needed, and collaboration with vendor partners improve adoption

• Results achieved by early-adopter Phase I implementing health plans include:
  – Payback was less than one year (considers only shift from telephone to electronic verification)
    • One-time costs of implementation/Phase I CORE Certification  $ 542,800
    • Annual ongoing costs  $ 49,200
    • Annual savings due to shift from telephone to electronic  $ 2,666,800
    • Ratio of verifications to claims  Up from .63 to .73

* IBM assessed results achieved by Phase I CAQH CORE Operating Rules early adopters (represents 33 million covered lives and 1.2 million providers)
The Business Case: Providers

The CAQH CORE Operating Rules for the Eligibility transaction result in an optimization of provider financial workflows

- Providers that adopt Phase I CAQH CORE Operating Rules reported significant improvements in access *at or before the time of service* to:
  - Health plan eligibility
  - Benefit coverage
  - Patient financials

- Results achieved by early-adopter providers/hospitals working with vendors and health plans that have implemented the CAQH CORE Operating Rules* include:
  - **Primary benefits**
    - Decrease in claim denials (related to eligibility) *10-12%*
    - Percent increase in electronic eligibility verifications *24%*
    - Save 7 minutes per electronic verification *
  - **Secondary benefits**
    - Time saved in registration and billing
    - Reduced transaction fees and connectivity costs

* IBM assessed results achieved by Phase I CAQH CORE Operating Rules early adopters (represents 33 million covered lives and 1.2 million providers)
CAQH CORE Operating Rules: Impact to Third Party Administrators

• Value Add:
  – Streamline administrative transactions through vendor-agnostic operating rules
  – Increase transparency to help manage flow of benefits
  – Automate processes to reduce paperwork
  – Improve revenue cycle management
  – Ensure accurate, real-time exchanges, even when offering customized services

• Consistent and Robust Data:
  – Bring more information to clients in a more consistent manner to accelerate payment services

• Types of Offerings enhanced by CORE:
  – Electronic Claims Management
  – Reporting & Analysis
  – Remittance
  – Eligibility
  – Identity Check / Patient Verification
  – Cost Calculation
  – Direct EDI Connectivity
Industry Collaboration: Impact to Third Party Administrators

- Understand the electronic data flows associated with your various administrative arrangements
- Vendors and trading partners play a crucial role in accelerating provider adoption and ROI; engage them
- Small providers rely on their vendors/PMS to achieve their administrative cost-saving goals; keep them apprised of your progress
- Involve internal departments in operating rule implementation planning discussions
Trading Partner Relationships: Payer Examples

- Payers and clearinghouses work together in numerous ways; a third party administrator’s role and responsibilities relative to its trading partners impacts the scope of its implementation effort, e.g.,
  - **Payer A**
    - TPA / health plan supports CAQH CORE Operating Rules in their entirety
    - TPA / health plan’s implementation is independent of any clearinghouse relationship
  - **Payer B**
    - Infrastructure and connectivity functions outsourced to a clearinghouse
    - Both TPA / health plan and clearinghouse pursue implementation activities
    - TPA / health plan-facing clearinghouse acts as a proxy for agreed upon functions
  - **Payer C**
    - Eligibility and benefit verification (and/or claim status) functions outsourced to a clearinghouse, including data hosting
    - Clearinghouse supports CAQH CORE Operating Rules in their entirety
    - Clearinghouse’s implementation is independent of its relationship to health plan
    - TPA / health plan-facing clearinghouse acts as a proxy for agreed-upon functions
**Nine Months to the Mandate: Key Implementation Activities**

A solid understanding of the CAQH CORE Operating Rules combined with an effective planning effort is the basis for successfully implementing mandated operating rules.

<table>
<thead>
<tr>
<th>Activities</th>
<th>Key Points</th>
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<tbody>
<tr>
<td>a) Discover and master</td>
<td>Understand and thoroughly review CAQH CORE Phase I and Phase II Operating Rules. They are publicly available for free at <a href="https://www.caqh.org">v5010 CAQH CORE Operating Rules</a> on the CAQH website; will drive v5010 ROI</td>
</tr>
</tbody>
</table>
| b) Pre-implementation planning and analysis     | • Determine which CAQH CORE Operating Rules apply to your organization  
• Understand the role of your trading partners  
• Utilize the CAQH CORE Planning & Analysis Tools, i.e., [Gap Analysis](https://www.caqh.org) and [Planning Guide](https://www.caqh.org), to:  
  – Identify where current capabilities require system enhancement  
  – Determine project requirements |
| c) Create a project plan                        | Implement formal project management practices in alignment with systems development life cycle        |
| d) Execute Your Implementation Plan            | Eligibility and Claim Status Operating Rule mandate effective as of January 1, 2013                |
CAQH CORE Rules Analysis & Planning Tools

**Stakeholder & Business Type Evaluation:**
**Objective:** Understand what aspects of your business and/or outsourced functions are impacted by the CAQH CORE Operating Rules (e.g. products, business lines, etc.)

**Systems Inventory & Impact Assessment Worksheet:**
**Objective:** Understand how many of your systems/products are impacted by each CAQH CORE Operating Rule and understand with which vendors you will need to coordinate.

**Gap Analysis Worksheet:**
**Objective:** Understand the level of system(s) remediation necessary for adopting each CAQH CORE Operating Rule requirement; results of completed Gap Analysis Worksheet will allow for development of a detailed project plan.

Each of the above tools can be found in the CAQH CORE Analysis & Planning Guide.
## FAQs

- CAQH CORE has a list of FAQs to address typical questions regarding the operating rules, and is in the process of reviewing these FAQs and updating as appropriate given mandates.

## Education Sessions

- There are frequent, often free sessions with partners such as WEDI, CHIME and Medicaid, and many include speakers from organizations that have already implemented the rules.
- 2011 sessions are available for download on the CAQH CORE website.

## General/Interpretation Questions

- Email CORE@caqh.org
- Email CAQH CORE staff regarding request for interpretations or general questions; calls can be arranged.
- Request process in place to provide prompt responses.

All CAQH CORE Operating Rules are available free at [www.caqh.org](http://www.caqh.org)
Key Benefits of *Voluntary* CORE Certification

**What:** CORE Certification is awarded to organizations that *voluntarily* complete CORE Certification Testing; CORE Certification Testing is stakeholder specific and demonstrates that an applicant’s system(s) conform with CAQH CORE Operating Rules

**Why:** CORE Certification Testing offers a mechanism to test your ability to exchange eligibility and claim status transaction data with your trading partners

- Process offers useful, accessible and relevant guidance in meeting obligations under the CAQH CORE Operating Rules
- Encourages trading partners to work together on data flow and content needs
- Promotes maximum ROI when all entities in data exchange are known to conform with the operating rules
- Testing done on-line by CORE-authorized testing entity
Thank You For Attending: Stay Involved

• Ensure your organization is ready for the January 2013 Mandated Eligibility & Claim Status Operating Rules deadline:*
  – HIPAA v5010 Phase I & II CAQH CORE Rules
  – Phase I & II CAQH CORE FAQs

• Join us at another CAQH CORE Education Event:
  – Upcoming CAQH CORE Educational Session
  – Upcoming Public CAQH CORE Town Halls (click to add to Outlook Calendar)
    • April 24th, 3:00-4:00 pm ET
    • June 12th, 3:00-4:00 pm ET

• Learn the basics of voluntary CORE Certification

• Contact CORE@caqh.org regarding rule interpretations or to submit requests for information/clarification

*NOTE: In the Final Rule for Administrative Simplification: Adoption of Operating Rules for Eligibility for a Health Plan and Health Care Claim Status Transaction, requirements pertaining to Acknowledgements are not included for adoption.
Question & Answer